DOCUMENT RESUME

ED 240 457 CG 017 287

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TITLE After Suicide: Meeting the Needs of the Survivors.
PUB DATE Mar 83
NOTE 12p.; Paper presented at the Annual Convention of the American Personnel and Guidance Association (Washington, DC, March 20-23, 1983).
PUB TYPE Information Analyses (070) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Coping; *Counseling Techniques; Counselor Role; *Emotional Response; Family (Sociological Unit); Family Life; Health; Individual Needs; Significant Others; *Suicide; Widowed

ABSTRACT

Suicide is the tenth leading cause of death in the United States, with 30,000 documented cases per year. It is the eighth leading cause of death in children and the third leading cause of death in adolescents. For every suicide a minimum of five family members or significant others are affected. These survivors go through a difficult period of postvention, when they work toward emotional and psychological recovery and readjustment. Suicide, with its taboo and stigma, often cuts off normal avenues of grief support. All survivors, from immediate family members to friends to professional associates, feel responsible for the loss. The death is particularly traumatic because there is no warning, no ability to plan, and little support from others who are themselves uncomfortable with the suicide. Guilt, hostility, rage, anger, social stigma, loss, emptiness, and a prolonged period of self-questioning must all be dealt with. Professionals can provide assistance in meeting survivors' needs through recognizing the need for services, becoming aware of the dimensions of the problem, becoming knowledgeable in suicidology and bereavement, becoming skilled in techniques of self-help and support groups, and by working in an interdisciplinary manner. (BL)

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After Suicide: Meeting the Needs of the Survivors

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Abstract

Suicide is currently a leading cause of death in the United States. It is a particularly toxic form of death for those significant others left behind, survivors, to cope with and to place in the proper emotional perspective. This article deals with the recognition of suicide and its impact on the survivors. Some of the significant physical and mental health concerns of survivors are examined. The causes and types of trauma experienced by survivors are presented. Specific affective needs of the survivors and possible approaches to assisting this population are offered. This article grew out of presentations on this subject by the authors to a variety of helping professionals.

After Suicide: Meeting the Needs of the Survivors

Suicide is the tenth leading cause of death in our country today. Every year there are approximately 30,000 documented suicides in the United States (National Center for Health Statistics, 1982). Many of us who work in the area of suicide deaths believe that the actual number of suicides in the U.S. today is closer to 100,000. In one decade there are approximately 300,000 suicide deaths in this country.

If we assume a realistically low average of five family members that are seriously affected by the loss of a significant other for each suicide death, then this nation includes 150,000 suicide survivors who each year are involved in the difficult process of "postvention". Postvention is that process after a suicide during which an individual and/or a family works toward emotional and psychological recovery and readjustment to healthy living (Hatton, 1977). These are statistics for one year only. We are talking only about the immediate family. This is a conservative estimate.

Suicide is a serious problem in our country. It is the eighth leading cause of death for children age 5-14; and the third leading cause for young people age 15-24 (National Center for Health Statistics, 1982). Most people forget that suicide is not an isolated act that ends with the death itself. Survivors, those significant others left behind and alive, are sentenced to a warped and warping legacy of that suicide. For survivors, the tragedy is just beginning: "There is just not enough time to heal the wounds of a self-inflicted death. The crushing blow is a bitter experience

for all those left behind. They carry it in their hearts for the rest of their lives" (Grollman, 1961, p.109).

The act of suicide is a very intentional rejection of the world and its immediate human relationships. Dr. Edwin Shneidman, director of the Los Angeles Suicide Prevention Center and one of the foremost suicidologists in the nation explains, "It is as though the person who commits suicide puts his social skeleton in the survivor's emotional closet sentencing the survivors to a host of negative feelings and to obsessing about the causes for the suicide death" (Shneidman, 1971, p.456)

The act of suicide and its implications leave a mark on the survivors. The tragedy of suicide cannot be compared to any other crisis: it is separate and distinct from any other cause of death. This is a self administered death, and because of the taboo and stigma that exists concerning suicide, the survivors' feelings of blame, self doubt, anger, resentment, shame, guilt, and confusion are intensified. Normal avenues of grief support from family, friends and the community are often cut off in a suicide death. The survivor of suicide feels that they are living a stigmatized life, and are no longer able to be open with their feelings (Cain and Fast, 1966; Noyes, 1968; Solomon, 1982). Perhaps this sounds like an overstatement. Consider the statistical fact that survivors are more likely to attempt or complete suicide themselves than are members of the general population (Pfeffer, 1981).

Identifying Survivors

Exactly who are these survivors of suicide? Survivors are found in a variety of social settings and relationships to the person completing

suicide.

Immediate family members are usually hit particularly hard in the aftermath of suicide. They bear the brunt of the social stigma. Our society expects parents and a spouse to take care of other family members. Suicide can appear to others as a failure of one's nurturing responsibility. Brothers, sisters and even children are care givers who often imagine that they are responsible for these suicide deaths. Whether stated by others or not, the perception that others are projecting blame on the immediate family for the suicide is a heavy burden for the family to labor under.

Extended family members may be deeply pained by a suicide death of a grandchild, cousin or in-law. The impact may be greater than kinship lines would first indicate. The physical separation experienced by the extended family may leave them feeling a hopeless sense of failed responsibility.

Friends may find themselves in the process of suicide bereavement. All across the life-span, peers at various ages may easily understand and identify with the struggles and events that may led a close friend to take his/her own life. They, too, may feel responsible for not having recognized suicide or not having shared the clues with others.

Professionals in the helping professions such as counselors, psychologists, nurses, physicians, social workers, therapists and others may also be considered as survivor victims when one of their clients completes suicide. There is very little support available to the professional who "loses" a client while in their care. This is the type of event in a professional's career that is difficult to put in proper perspective personally

and also within the larger "agency" where the client was involved. The professional often feels a great sense of failure in their professional capabilities when a suicide death occurs.

Law enforcement personnel may become survivors if they become involved with a suicide which they could not prevent. Arrival at the scene a moment too late, or discovery after the fact in an incarcerated setting all weigh heavily on the mind and emotions of these law enforcement specialists. The community often is very critical of the police in these situations, accusing and implying that it may have been negligence that resulted in the suicide.

Finally, even the members of a rather large organization such as a church, a school, or a factory may experience suicidal bereavement when the organization loses one of its members. Here the impact would vary but commonly it is felt and perceived by the organization's membership as a failure to care for one of its members effectively.

Why the Loss is Traumatic

Certainly the death of a loved one is always difficult for those left behind. The loss of a significant person in one's life by an accident or suicide is swift and devastating. However, death by suicide seems to have several unique features with which the grieving survivors need to cope.

First, there is no warning and no ability to plan for the death. Frequently, death is an anticipated event. Suicide victims and their behavior often encourage others to deny the very warnings that may have prepared a survivor to deal with the shock of the death itself. This

suddenness and the often present aspect of denial combine to produce a profound numbness in the survivor.

Second, there is a profound guilt associated with a death by suicide. This guilt is not always present with other causes of death. The dramatic grief which survivors experience is unlike the impact of other deaths. Many survivors have experienced a number of deaths from a variety of causes. They all report that to them there are two kinds of death: suicide deaths, and all other kinds of death. This tremendous burden of guilt seems to be tied to the survivors' belief that they could have prevented this particular death. A survivor's guilt fosters feelings of unworthiness and a significant loss of self-esteem. The survivor knows that the suicide victim preferred death to life with them.

And third, the grief for survivors of suicide is most often a burden that they carry alone. Survivors are shocked and left emotionally unstable, and then find that due to the stigma often attached to suicide, they are unable to gain support and assistance from others who themselves are uncomfortable dealing with this toxic topic. Opportunities to share their feelings and to self-disclose are often unavailable. These then are some of the reasons why suicide survivorship is so traumatic.

Affective Areas of Survivorship

Survivors have a number of feelings that may prolong their grief. Guilt is difficult to avoid when there is no external cause to account for the death (e.g., disease, accident, etc.). Sustained hostility and rage at the suicide and what it has done to the survivors is common.

Anger for disrupted family life, financial concerns, health problems, and social stigma all are common resentments felt by a survivor. A sense of release from the pressures of dealing with a suicidal person are typical as well. Of course this relief often triggers further cycles of guilt and anger. Estrangement from family, neighbors and friends is typical because of the threatening nature of the death. Feelings of loss and emptiness and a sense of disbelief that this could happen are often followed by bouts of self-doubt and recrimination. Finally, a prolonged period of self-questioning: Why did it happen? Was I to blame? Did I cause it? What could I have done differently? If only I (we) had done this or that, would it have helped? All of these questions contribute to a state of prolonged affective turmoil.

Meeting Survivor Needs

What is it that can be done to assist the survivors of such a devastating form of death? There are really five areas in which professionals may provide help to survivors:

1. There is first of all a need for those in the helping professions to recognize that this is a significant area in which to provide services. Until recently there were very few communities that had any programs addressing the mental, social and personal health needs of survivors. In fact, most providers of care are resistant to even make contact with survivors of suicide. Often this is out of the mistaken fear that such contact would be inappropriate and upsetting to the survivor.

2. An awareness of the dimensions of the problem and a commitment to inform other helping professiona's of the scope of the problem is essential in initiating efforts to provide the needed services to this group.
3. Professional helpers need to become knowledgeable in the area of suicidology and bereavement so that they can provide the much needed information during a time when emotions distort reality about a subject that is already the source of many prevalent myths. Suicide survivors seem obsessed with acquiring knowledge about suicide, its causes, forms, effects and prevention. Working with the survivors necessitates that the professional becomes very familiar with the field of suicidology. Survivors simply expect helpers to be as knowledgeable as they are if they are to provide assistance.
4. Members of the helping professions should be familiar with the techniques of self-help groups and/or support groups. Helpers must possess the skills to initiate, publicize, convene and process such support groups. Survivors quickly find that they can provide each other with the necessary support, and the need for professional intervention rapidly declines. At this point, the helper needs to be able to "take-the-backseat" and allow the members to meet their own changing and varied needs.
5. Those who work with survivors quickly realize that it requires an interdisciplinary effort on the part of the coroner, the police, nurses, physicians, counselors, social workers,

psychologists and the clergy to meet the diverse needs of this population. No one profession can or should supply all of the answers or support.

Summary

The recognition of suicide and its impact on the survivors has been discussed. This is a significant physical and mental health concern in the U.S. today. Those who experience this trauma were identified and the reasons for such a profound impact on the lives of survivors was presented. The specific affective needs of the survivor and the approaches to assisting this population were discussed.

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